



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEVEN DOORES, MD
3523 MCKINNEY AVE #610
DALLAS, TX 75204

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-4904-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: From Table of Disputed Services: "nothing paid" and from a letter dated October 3, 2011: "This claim has been submitted followed by Request for Reconsideration without response. Subsequently a Medical Fee Dispute was filed ONE TIME not twice as alleged in the enclosed letter. There may have been some confusion in the tracking numbers listed by one of the parties. This office does not expect to be paid twice for one service."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: From a letter dated September 09, 2011: "Carrier will issue payment for Dr. Doores' services in the next few days. Carrier requests that this matter be dismissed as the issue is resolved." and a letter dated October 3, 2011: "The provider already submitted a request for medical dispute resolution for a date of service of May 20, 2011 for \$300.00. This request was submitted under M4-11-4902-01. The provider is asking for reimbursement for the same date of service, for the same healthcare service provided, and for the same amount as it requested under M4-11-4902-01. The provider is not entitled to reimbursement twice for the same date of service. Under M4-11-4902-01, the carrier indicated that it was in the process of reimbursing the provider."

Response Submitted by: Hartford c/o Flahive, Ogden & Latson, P.O. Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| May 20, 2011 | 99456-WP-W5 | \$300.00 | \$300.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
No explanation of benefits was provided by either party.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. A phone call to requestor on February 17th, 2011 verified that no payment has been received per the original intention of this MFDR filing and that there may have been some confusion on the part of one or more of the parties as to tracking numbers. A review shows that the other MFDR file included information for another injured worker and is no longer a consideration in this dispute. The issue to be resolved is whether payment for the May 20, 2011 DD examination was paid on this service for this injured worker. Therefore, this issue will be reviewed according to applicable fee guidelines and after review of supporting documentation.
2. The requestor billed the amount of \$300.00 for CPT code 99456-W5-WP for a DD examination for Impairment Rating (IR) only as MMI was already certified by another physician. Documentation supports a Range of Motion (ROM) IR method on the wrists/elbows (upper extremities) for a MAR of \$300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a).
3. Respondent has not paid any amount on CPT code 99456-W5-WP, therefore \$300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 23, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.